Testimony of Grey Gardner, Senior Policy Counsel, Drug Policy Alliance
In Support of H. 72 (Authorizing Overdose Prevention Centers)
Vermont Senate Health and Welfare Committee
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Thank you, Chair Lyons and members of the committee. I'm Grey Gardner - I serve as a senior policy counsel for the Drug Policy Alliance. DPA is the leading organization working to eliminate drug policies that cause harm to individuals and communities, and replace them with evidence-based policies grounded in health, equity and human rights.

Overdose prevention centers, or OPCs, are not radical, not unusual, and they're not unlawful.

They're a reality throughout the world. And as academic experts Brandon Marshall and Alex Kral explained last week, they're effective in saving lives, reducing emergency response costs and infectious disease, reducing public use and litter, and connecting people to an array of supportive services that help promote stability and build bridges to treatment and recovery.

Dr. Marshall, Dr. Kral and others have detailed some of the vast research that has been conducted to study OPCs; and I found it striking that Dr. Kral said that the studies have uniformly found positive benefits OPCs. He emphasized that "no peer-reviewed study has found any negative impact of OPS."

In just over two years we've seen that effectiveness clearly demonstrated by the two sites operated by OnPoint NYC in New York, which are not just providing supervised consumption, but they're serving as model health and wellness hubs for people who use drugs.[1]

Testimony in the House and in this committee have already laid out much of the success in New York and the thoughtful approach that Rhode Island has taken over the past 5 years to conduct studies, pass legislation, enact regulations, and fund an initial harm reduction center site that is slated to open later this year.[2]

So in my testimony today I want to highlight the broad support across the country and in Vermont for allowing the establishment of similar facilities in Vermont. I also want to address some of the questions and concerns that have come up in the debate and discussion surrounding this bill - questions such as (1) Is this something that makes sense for a state like Vermont, (2) Is this a good use of resources, and (3) are there legal obstacles to doing this?

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[1] Dr. Brent Gibson, PhD, Kailin See, Brittney Vargas Estrella, Sam Rivera, Baseline Report on the Operation of the First Recognized Overdose Prevention Centers in the United States (December 2023). https://onpointnyc.org/wp-content/uploads/2023/12/ONPOINTNYC_OPCREPORT_small-web1.pdf

[2] Katie Mulvaney, $2.25M from opioid settlement dedicated to help RI create safe drug consumption site, PROVIDENCE J. (July 22, 2022), https://www.providencejournal.com/story/news/courts/2022/07/22/opioid-settlement-funding-ri-safe-drug-consumption-harm-reduction-centers/10126536002/

The short answer is that it certainly makes sense, it's desperately needed, tremendously cost effective, and there's no clear legal barrier preventing the state from joining Rhode Island and moving forward now to save lives.

Vermont's Continues to Experience a Severe Overdose Crisis

I know Some of this has been mentioned by prior witnesses, but it bears repeating that Vermont continues to be in a severe health crisis. If we look at loss of life it far surpasses COVID-19.

In the slides I'm showing the graph on fatal drug poisonings dating back to 2010 - I'm sure the Committee has seen this many times, but it's important to recognize the continued rise in loss of life over the last decade, particularly in the past 8 years.

Back in 2014 this was already considered an epidemic - because at that point fatalities had nearly doubled in the previous 5 years. But since then - in the years following 2014 - we've seen more than 1,500 Vermonters die from drug poisoning.[3]

And in just the past 3 years we've seen record levels. Regardless of whether those numbers are continuing to rise, or leveling off, or maybe even decreasing nominally it's hard to overstate how much of a continuing, imminent emergency this presents.

Anyone that says that the existing approach to saving lives is working may not have a complete view of what's happening.

This is a situation that calls for new approaches, more resources, and more emergency efforts to look for every way possible to reach more people who are at risk and break down barriers that prevent them from getting support they may need.

The Gap in Our Continuum of Care

Before I talk more about why OPCs must be a critical part of future efforts to address this crisis, I want to talk about some of the work that's been done in the past and where the state can still do more.

Vermont has been on the leading edge of drug policy reforms for years, and we recognize that much of that leadership has come from this committee and others in the legislature: Creating syringe services programs, developing the hub-and spoke treatment model and making methadone available, making naloxone widely accessible, removing criminal penalties for possessing buprenorphine; and last year passing one of the first comprehensive, community-based drug checking laws in the country.

[3] Fatal Overdoses Among Vermonters: Annual Data Brief – Data through 2022. Vermont Department of Health (April 2023).

DPA has worked with partners in Vermont for years to support these policies, which in large part center around the concept of harm reduction.

Harm reduction is a series of strategies, tools and interventions that recognizes that people engage in high risk practices - whether it's drug related or in terms of their sexual or other practices - and the acknowledgement that abstaining from those behaviors may not be practical, feasible or tangible at a given point in time for all people. So it's an approach focused on helping people who may continue to engage in high risk practices to explore reduced risk techniques or strategies to keep themselves and their communities safer.

It's often described as "meeting people where they are" - acknowledging that the drug use is happening and trying our best to engage with those individuals in ways that promote health - similar to the way our society has approached mandating seat belts in vehicles, requiring harm reduction equipment such as cigarette filters, and in many other ways.

I've heard it said recently that the state's strategy to address the overdose crisis is built on "4 pillars: prevention, treatment, recovery and enforcement." If that characterization is correct, it leaves out one of the most important strategies for reducing fatalities - harm reduction. Placing less emphasis on harm reduction in any comprehensive strategy leaves a huge number of people at risk - those who find themselves using substances problematically, despite our prevention efforts, and for a wide range of reasons aren't ready or in a position to access treatment.

For many reasons there are people who right now are not engaging with treatment that might be available to them or for some reasons may be difficult to access. Some individuals may not think they need treatment, some might be trying to maintain a job or for family reasons don't want to be open about their use, or who may just think it can't be effective for them. Some have been to treatment many times and in some cases may have felt stigmatized and further marginalized from those interactions.

It's precisely this gap between prevention and treatment where some Vermonters are falling through the cracks. Vermont has some incredible organizations providing innovative treatment and recovery services. And we have some amazing harm reduction service providers in Vermont who are doing truly heroic work with some very tight budgets, but they can only do so much to keep clients safe. Under the current model, with someone who they know is going to use a substance that may or may not contain toxic quantities of a chemical compound, they cannot allow and monitor that use to occur in a clean space, ensuring the use of sterile equipment, perhaps advising on safer consumption strategies; and importantly, they can't be there to jump in - or even call EMS - at the first sign of an emergency.

I think when people realize what the OPC model really does, they see that it's just better to fill that gap in the continuum of care. To surround people who use drugs with people who aren't going to judge, shame, demand abstinence, sanction them or further marginalize them. To instead provide the same level of support and care that we want from evidence-based treatment

and recovery programs, and to meet people where they are instead of leaving them on their own until they're convinced to enter and sustain treatment.

Continuing to look for ways to enhance treatment and recovery services are certainly important. But states cannot meet this moment of crisis by continuing the status quo and failing to significantly expand harm reduction services that meet people where they are.

That need, and the evidence showing the benefits of OPCs appear to be one of the primary reasons that leading health associations, including organizations representing treatment professionals, support states moving forward to enact pilot projects that include OPCs like Rhode Island's harm reduction center program.

Notably, the American Medical Association (AMA)[4] and the American Society of Addiction Medicine (ASAM)[5], and the American Academy of Family Physicians (AAFP)[6] all have adopted policies in recent years that recognize the value and effectiveness of OPCs as an effective harm reduction strategy. The Association for Multidisciplinary Education and Research in Substance use (AMERSA) also recently adopted a new policy statement supporting OPCs as well[7].

And extensive support for OPCs has been expressed to this committee directly in letters or in other ways by numerous other national and Vermont-based organizations representing public health interests, faith-based groups, housing and homeless advocacy organizations, current and former law enforcement professionals, prosecutors, businesses, civil-rights advocates, and many others. And notably there are many treatment and recovery professionals in Vermont, other health practitioners, and hundreds of others who have expressed support for OPCs.

<u>We Must Address the Enormous Problem of People Using Alone</u>

As Mr. Roberts and Ms. Kirby mentioned yesterday, one of the biggest problems we face in Vermont and throughout the country is the fact that too many people are using substances

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[4] American Medical Association, "Pilot Implementation of Supervised Injection Facilities H-95.925", available at https://policysearch.ama-assn.org/policyfinder/detail/supervised%20injection?uri=%2FAMADoc%2FHOD.xml-H-95.925.xml (last accessed March 27, 2024)

[5] American Society of Addiction Medicine (ASAM), Public Policy Statement: Overdose Prevention Sites (adopted July 22, 2021), available at: https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2021/08/09/overdose-prevention-sites (last accessed March 27, 2024)

[6] American Academy of Family Physicians (AAFP), Needle Exchange Programs and Safe Injection Sites, available at https://www.aafp.org/about/policies/all/substance-use-disorders.html#harm (last accessed March 27, 2024)

[7] Association for Multidisciplinary Education and Research in Substance use and Addiction, available at https://amersa.org/wp-content/uploads/OPC-Position-Statement-FINAL.pdf (last accessed March 27, 2024)

alone. If states are serious about reducing fatalities in the most impactful way they have to prioritize helping people who are actively using drugs not use alone.

The way we've done this in recent years in Vermont is for the Health Department to make statements and put out documents "urging that people not use alone."

That's certainly important. But how can we keep just saying to people who are often stigmatized in their communities, who often don't feel welcome even among people they have previously been close to, and who have often been marginalized through our policies… that they should just make sure to have someone with them when they're using a substance? I'm not in any way devaluing those efforts - it's important to effectively get that message across - but to some extent it rings hollow when we're not saying "here's a place you can go where there are people you can trust to help."

The most recent data from the Health Department backs up what was described in previous testimony - that the vast majority of people have no bystander present at the time of a fatal overdose. In the most recent data available from 2021 (as shown in the Department of Health graphic in the slides), 41 percent of the people who experienced a fatal overdose did not have a bystander present at the time of use or when responders arrived. In another 27 percent of the cases it was unknown.[8] I think in many of those cases where it's unknown it's fair to say that IF there was someone there originally, there's a strong likelihood that people were too afraid to remain at the scene or just didn't know what to do.

Either way, it's a tragedy that "most people who overdosed did not have a bystander present," as summarized in the health department's table included in the slides.

The other thing Vermont and states are increasingly promoting is the widespread distribution of naloxone. We tell people to carry naloxone and that's extremely important - but I think it's also important to be mindful that people experiencing overdose don't often administer Naloxone to themselves. And the reality is that many people often don't have people they can fully trust to watch over them when they're using a substance.

Vermont enacted one of the stronger Good Samaritan laws in the country, but from conversations I've had with some who have more direct experience, many people who use drugs continue to fear that they will be blamed if they're found with someone who has overdosed.

So instead of just telling people they shouldn't use alone, we should support making spaces available where people are actually welcomed. Where they're surrounded by people that are trying to look out for them, offering support when and if it's desired, provided basic medical care, showers and laundry if needed, and treated with dignity and respect.

[8] Vermont Social Autopsy Report: 2021 Data Analysis. Vermont Department of Health (August 2023).

That's a pragmatic approach. It builds trust, connections, saves taxpayer money that would be spent on very costly ambulance runs, emergency department visits, or long term infectious disease treatment. Increasingly, even many in law enforcement in places where OPCs are in effect - for example in Vancouver, Canada and in New York City - tend to be supportive of the centers. In speaking about OnPoint, a senior Chief in the New York Police Department has said

> *I've been in this business a long time... Maybe 5 years from now, we will be reacting to OPCs like we do safe syringe exchanges. That's where we are heading. It's going to be a no-brainer shortly."*
>
> *- Theresa Tobin, Theresa Tobin, Chief of Interagency Operations, NYPD*[9]

Given the interest states throughout the country in visiting and replicating OnPoint's model, there is reason to hope that Chief Tobin is correct.

The Concerns Raised Do Not Merit Any Further Delay in Implementing OPCs

So, the question should not be "are we comfortable with OPCs" - or "can this really work in a state like Vermont" - or should any new funding just go to expanding what we're already doing." It should be, "are we doing absolutely everything possible to reach and save the lives of the people who are at the greatest risk of dying right now?"

As it stands right now, the continuum of care has a wide gap that exists during the times that clients with substance use disorder are left out to be on their own, when they're in periods of active use. And we know that if they consume in a public place in some localities, they may be arrested. If they're using in their home, or a tent, or under a bridge, an overdose may not be recognized, they may be victimized, and they may be exposed to higher risk for other health conditions.

I completely understand that creating centers like this may be counterintuitive and uncomfortable for some. For many people the first thought is that we would be enabling continued use. The fact is that the use is happening, whether it occurs under a bridge or behind closed doors, it's happening. Allowing OPCs brings that use indoors, into a controlled setting, where there's more support and proper disposal of used equipment.

Rural Nature of Vermont: One of the questions that's been raised for years now has been that Vermont is such a rural state, how can OPCs work effectively?

Yes, as Dr. Marshall indicated they do operate in rural areas, particularly utilizing mobile models. But it's also important to recognize that every part of our systems of care are challenged by the same issues created by differences in population densities throughout the state. We've been

[9] OnPoint NYC, "Part of the Community", available at https://onpointnyc.org/onpoint-nyc-part-of-the-community/#:~:text=Theresa%20Tobin%2C%20Chief%20of%20Interagency.we%20do%20safe%20syringe%20exchanges (last accessed March 27, 2024)

continually seeking ways to expand treatment access to Vermonters who live in rural areas, and remove barriers that lead to difficulties many people in rural areas encounter in navigating legal and program requirements.

If this bill ultimately authorizes a pilot project for just two sites it will certainly be difficult to reach everyone in the state - but we will reach many who desperately need and want this. We have similar challenges with many other types of services and it doesn't prevent us from initiating the work to reach as many people as we can.

Use of Resources: Another point that's been brought up is whether there might be other alternative uses for whatever funds might be appropriated for OPCs.

I think it's fair to say that more resources are needed for a wide range of needed services and supports - especially other harm reduction services. We need much more investment to support existing organizations like our syringe service programs (SSPs) and make sure that we're providing both increased resources and flexibility so that we can utilize more organizations that have the knowledge, experience and connections to serve at- risk populations throughout the state.

The amount that is currently being considered to pilot harm-reduction centers in Vermont is one that does not take away from the important work that's underway focused on prevention, treatment and recovery. This funding would complement and supplement that work. We know that OPCs frequently provide a vital bridge to treatment and recovery.

The other point I want to make on this is the return on investment that this provides. Emergency response services are stretched thin throughout the state - and extensive research has now shown that in fact calls for EMS and admissions to emergency departments are reduced significantly from OPCs intervening before many cases escalate. Those result in substantial benefits that have been documented in the literature, showing net cost savings resulting from the initial investment.

Federal Legal Issues: One of the other frequently cited concerns that's been raised is the fear that this might conflict with federal law. I'll focus most of my remaining testimony on this question because it's neither precise nor entirely correct when some state that OPCs are "illegal" and that states should not act in the face of uncertainty about federal intervention.

The argument is based on a minor part of the Controlled Substance Act that was intended to criminalize trafficking and selling of drugs from homes or other properties. That law was passed before OPCs had been established widely throughout the world. Throughout it's history the section of law has been commonly referred to as the "crackhouse statute." That provision, (21 USC 856), makes it unlawful to "knowingly lease, rent, use, or maintain any place, whether permanently or temporarily, **for the purpose of** manufacturing, distributing, or using any controlled substance." (Emphasis added.)

Many legal scholars and law enforcement leaders (including many state attorney generals, prosecutors, and former Department of Justice officials) believe that federal law does not prohibit interventions like OPCs - particularly when they are authorized by states.

This was first tested in the Courts when, during the prior Administration, the Department of Justice supported efforts by the state of Pennsylvania to prevent an organization in Philadelphia from opening what would have been the first OPC in the United States, called Safehouse. They sought an injunction - a court order preventing the site from opening. The Judge, after hearing evidence and receiving input from interested organizations and officials all over the U.S., ultimately decided that the federal statute was never intended to criminalize harm reduction providers who would set up an OPC **for the purpose of saving lives.**[10] The key factor in the decision was that Safehouse was not trying to create the space "for the purpose of"... manufacturing, selling or using.

That opinion recognized what many scholars, medical associations, and even former federal prosecutors had said - that these sites serve a medical purpose and that the Controlled Substances Act should not be used to prevent them.[11]

Some of the officials who joined legal briefs supporting the Safehouse position at various points throughout the legal process included States Attorneys from 10 states plus the District of Columbia. **Former Vermont Attorney General T.J. Donovan, Former U.S. Attorney Jerome O'Neill and former Attorney General Kimberly B. Cheney all joined various legal briefs supporting states' rights to establish OPCs.** One of those briefs stated that

> *unlike crack houses or raves, (OPCs) do not distribute, manufacture, or encourage drug possession, but rather "serve a medical purpose by providing counseling to people with a substance use disorder, preventing overdoses, and stopping the use of dirty needles. . . (OPCs) thus do not present the identified dangers that Congress feared when Section 856 was enacted.*[12]

[10] United States v. Safehouse, 408 F.Supp.3d 583, 592 (E.D. Penn. 2019). d. at 593. ("[T]here can be no question that Safehouse's approach to harm reduction and increasing access to treatment was not within the contemplation of Congress when it enacted or amended this statute." Id. at 615.)

[11] See e.g. amicus brief of Drug Policy Alliance, American Medical Association et al. supporting Appellee Safehouse, July 2, 2020 to the Third Circuit Court of Appeals, available at: https://www.safehousephilly.org/sites/default/files/attachments/2020-07/amicus%20in%20support%20amended%20brief%20of%20AIDS%20United%20et%20al.%207.3.20.pdf (last accessed March 27, 2024)

[12] Amicus brief by the District of Columbia and nine states in U.S. v. Safehouse, July 6, 2020, available at https://www.safehousephilly.org/sites/default/files/attachments/2020-07/Brief%20of%20The%20District%20of%20Columbia%20and%20The%20States%20of%20California%20et%20al.%207.20.20.pdf (last accessed March 27, 2024)

There were many organizations, cities and county officials, health and housing advocacy organizations, active and former law enforcement officials, and faith based organizations that also expressed support supporting the Safehouse position.[13]

That case was litigated in the Eastern District of Pennsylvania and when the United States appealed the case to the Third Circuit Court of Appeals, that appellate court ultimately reversed the lower court's opinion and sent it back, where proceedings are continuing on other religious liberty claims. The Third Circuit opinion has been criticized by some scholars for failing to consider the legislative history of the statute in analyzing the issue.

And that Third Circuit decision, to be clear, is not "binding" on other federal circuits, including the Second Circuit which includes in its territory the states of Vermont, Connecticut and New York.

It's also important to note that even though OPCs have now been open in New York for over two years, and Rhode Island has authorized its first OPC to open this year, there have been no attempts under the current administration to interfere with those efforts… no efforts to seek an injunction or take other action.

There have also been a number of encouraging statements by federal officials, including the director of the National Institute on Drug Abuse (NIDA), who have recognized the research showing that OPCs save lives, and are now providing federal funds to evaluate the impacts from the New York and Rhode Island programs.[14]

Notably, **a spokesperson for the Department of Justice reportedly has said "that supervised consumption sites were being evaluated on a district by district basis, in discussion with local leaders, to determine 'appropriate regulatory guardrails.'"**[15] This Committee's work and the regulatory process that would follow enactment of this bill are part of that process of developing appropriate regulatory guardrails to make sure that OPCs authorized

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[13] Brief of Drug Policy Alliance (DPA), AIDS United, American Medical Association (AMA), Association for Multidisciplinary Education and Research in Substance Use and Addiction (AMERSA) et al. in support of Appellee Safehouse Seeking Affirmance of Order Granting Final Declaratory Judgment. July 3, 2020, Available at: https://www.safehousephilly.org/sites/default/files/attachments/2020-07/amicus%20in%20support%20amended%20brief%20of%20AIDS%20United%20et%20al.%207.3.20.pdf (last accessed March 28, 2024).

[14] Corrie Pikul, Brown researchers to study ability of Rhode Island's first overdose prevention center to counter overdose crisis, BROWN UNIV. (May 8, 2023), available at: https://www.brown.edu/news/2023-05-08/opc-evaluation (last accessed March 28, 2024).

[15] Jennifer Peltz & Michael Balsamo, Justice Dept. signals it may allow safe injection sites, ASSOC. PRESS (Feb. 7, 2022), available at https://apnews.com/article/business-health-new-york-c4e6d999583d7b7abce2189fba095011. Sharon Otterman, Federal Officials May Shut Down Overdose Prevention Centers in Manhattan, N.Y. TIMES (Aug. 8, 2023), (last accessed March 28, 2024). https://www.nytimes.com/2023/08/08/nyregion/drug-overdoses-supervised-consumption-nyc.html.

by the state have the necessary policies and protocols to protect participants, program providers, and the community.

Even if more federal courts interpret the disputed federal statute to at least permit federal intervention, the federal law should not serve as a barrier to opening OPCs any more than federal drug laws have impeded establishing legal, regulated access to cannabis in the states. Despite federal cannabis prohibition a large majority of states provide medical access to the substance and nearly half regulate access to cannabis for non-medical adult use.

States have broad power to regulate public health strategies that provide protections against arrest - like Vermont's "Good Samaritan" law, the "drug checking" bill passed last year, and the permanent decriminalization of unauthorized low-level possession of the treatment medication, Buprenorphine. The continued existence of federal laws prohibiting possession of drugs did not prevent Vermont or other states from passing such laws that prioritize saving lives over criminalization.

The most important takeaway here is that there's nothing preventing Vermont from stepping up to authorize OPCs and begin building the regulatory framework for OPCs. Even if the Second Circuit were to someday be called upon to interpret this statute, there is no reason to think that it would reach the same conclusion as the Third Circuit and I suspect that even more states that are now considering authorizing OPCs would join opposition to any such federal overreach.

Conclusion:

As you consider this legislation, it's important to recognize how much has changed since Vermont started exploring overdose prevention centers over half a decade ago. The illicit drug supply has become more unpredictable and more toxic. We have a drug poisoning crisis that is far worse and more people are struggling due to a variety of social and economic factors. However, we've learned a great deal more about the impacts of OPCs. A substantial body of research has shown the benefits to both individuals and communities, without any documented negative impacts.

Overdose prevention centers help bring public drug use indoors, keep people safe and connect them with care. There is no time to waste for Vermont to join Rhode Island in moving forward on this critically needed intervention to protect lives and better care for those needing wrap-around services in the state.

Thank you for your consideration and for the invitation to provide this testimony today.